

State of Oklahoma
Oklahoma Health Care Authority
Iclusig[®] (Ponatinib) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Pharmacy billing (NDC: _____) Start Date (or date of next dose): _____
Dose: _____ Regimen: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Please indicate diagnosis and information:

- Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL)
 - A. Induction/consolidation with HyperCVAD? Yes ___ No ___
 - B. Maintenance therapy in combination with vincristine and prednisone, with or without methotrexate and mercaptopurine? Yes ___ No ___
 - C. Maintenance therapy post-hematopoietic stem cell transplant? Yes ___ No ___
 - D. Relapsed/refractory disease either as a single-agent, in combination with chemotherapy not previously given, or in patients with T315I mutations? Yes ___ No ___
- Chronic Myeloid Leukemia (CML)
 - A. T315I mutation? Yes ___ No ___
 - B. Intolerant or resistant to all other Tyrosine Kinase Inhibitors (TKIs)? Yes ___ No ___
 - i. If yes, please provide additional information regarding TKIs member is intolerant or resistant to: _____
 - C. Post-hematopoietic stem cell transplantation in patient with prior accelerated or blast phase prior to transplant or who have relapsed? Yes ___ No ___
- Other, please provide diagnosis: _____

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on ponatinib? Yes ___ No ___
3. Has the member experienced adverse drug reactions related to ponatinib therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.